

DEPARTMENT OF HEALTH SERVICES**RADIOLOGIC HEALTH BRANCH**

P.O. BOX 942732, MS-178

SACRAMENTO, CA 94234-7320

(916) 445-0931

**ACCOMMODATION REQUEST**

If you have a disability that requires an accommodation in testing, please provide documentation from an appropriate professional (education professional, doctor, psychologist, psychiatrist, etc.) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation you may submit such documentation.

The information requested below, and any documentation regarding your disability and your need for accommodation in testing, will be considered strictly confidential and will not be shared with any outside source without your express written permission.

| | | | |
|--------------------------|------|------------------------------|----------|
| Name | | Telephone number () | |
| Address (number, street) | City | State | ZIP code |
| Accommodations requested | | | |

| | |
|-----------|------|
| Signature | Date |
|-----------|------|